

Carefully, compassionately: Canadian lessons on assisted dying

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By Gideon Salutin

Objectors to assisted dying policy often cite Canada's Medical Assistance in Dying (MAID) programme to exemplify the danger of doing so, including concerns about due process and eligibility. The following briefing is designed to evaluate where Canada has gone wrong, why it should not deter policymakers in Britain, and how we learn from Canadian mistakes to ensure assisted dying can be safe.

KEY POINTS

- Criticisms of Canadian policy focus on procedure and eligibility, but these can be safeguarded by following policies in place in other countries
- Procedural and administrative problems have been overlooked in Canada
 - This includes allowing staff without appropriate qualifications to assess assisted dying applications, and failing to provide adequate training to screen cases
- Expanding eligibility to those with non-terminal conditions raised concerns
 - Advocacy groups warned that the bill unfairly targeted disabled and impoverished people, and lacked safeguards against misuse

RECOMMENDATIONS

- Detailed procedures should be legislated which provide clarity to physicians
 - Clear guidelines should require physicians to evaluate each case
 - Patients should be the first to request assisted dying
 - Oral medication should be the default method for assisted dying
- Active oversight over each case should be enshrined to safeguard due process
 - Specially trained consultants should be available to assist in complex cases
 - Regional committees should investigate case and penalise bad behaviour
 - Data should be closely monitored, collected and shared
- Alternatives should be available so no one accepts assisted dying before they wish

FOREWORD

The issue of ‘assisted dying, or ‘choice at death’, has renewed prominence. At the time of writing, a Private Member’s Bill is being prepared with the government promising sufficient time for the matter to be considered and a free vote to be held. This will take place, at second reading, in a matter of weeks – and Parliamentarians are delving into the ethical, legal and moral issues.

As a long-standing proponent of reform in this area, one of the most frustrating aspects of the debate is the prominence of false assertions, myths or generalisations that are proffered by both sides. This paper on lessons from Canada, therefore, comes at an opportune moment.

Most strikingly, perhaps, is the very different constitutional framework in Canada and the genesis for reform to assisted dying laws. The introduction of Medical Assistance in Dying (“MAID”) in 2016 was undertaken after the Canadian Supreme Court found that the status quo was not compliant with Canadians’ constitutional right to life, liberty and security of person.

In fact, the failure of Parliament to grasp the nettle meant, in this context, the courts were forced to act. This tension led to incremental widenings in the scope of the legislation, including the addition of those suffering but not facing foreseeable natural death. Only Parliament, and devolved equivalents, would make such changes here in the UK. Comparing the ‘slippery slope’ in Canada to our laws is unhelpful and inaccurate.

That mistakes were made in Canada does not mean they need repeating. Indeed, lessons must be learnt. This paper sets out the importance of ensuring the legislation clearly focuses on those with terminal illnesses (as opposed to incurable chronic conditions), as the proposed Private Member’s Bill seeks to do. Any opening to cases of physical and/or mental suffering appears impossible to regulate adequately, however unfortunate that may be.

The legislation needs to err on the side of caution. For example, assisted suicide is different to euthanasia, providing for more autonomy and reflection for those approaching the end of their life. The starting point for any discussion as to assisted suicide must come from the patient, not the physicians. All reasonable alternatives should be exhausted. Indeed, as has happened in other jurisdictions where reform has occurred, there should be renewed investment and focus on palliative care. Oversight must be assured – whether judicial, or by trained physicians. Another consideration, not explored in this paper, is the presumption of capacity, as in the Mental Capacity Act, and whether this should be reversed in cases of assisted suicide.

Wherever you stand on the debate, it is imperative that this paper is read and digested properly. It not only explains the fundamental differences in Canadian law as to what is being proposed here, but goes to the origins of some of the problems encountered there and makes useful proposals to avoid the same fate. Ultimately, this endeavour – learning from others – to ensure that we decrease the numbers of those that suffer unnecessarily at the end of their life, whilst offering strong safeguards, is the position of a majority of the public. We shall see whether this bill, and this Parliament, ensures this will be given effect.

By Jake Richards MP

Britain is interested in Medical Assistance in Dying, but is concerned about Canada's experience

On the 29th of November, MPs will have a free vote on whether to legalise assisted dying for terminally ill adults in England and Wales. This would give doctors the authority to help eligible individuals end their life if they wish to do so. The policy appears popular: an Opinion poll conducted in Britain in 2024 found 75% of respondents supported assisted dying, with just 14% opposed.¹ When the Nuffield Council on Bioethics assembled a citizen's jury to discuss how England might introduce assisted dying, 22 out of 28 jurors agreed that it should be available to those with terminal conditions.² Bills are already progressing in Scotland, the Isle of Man, and Jersey.³

In response, the policy's opponents have released a wave of criticism against Canada's Medical Assistance in Dying (MAID) policy, which they claim represents a slippery slope which Britain could tumble down if it legalises assisted dying. A *Spectator* column described the policy as "the catastrophe unfolding in Canada," while a *Times* headline simply asked "Has it gone too far?"⁴

But Canada's new role as the lightning rod for assisted dying criticism is a miscast. Its experience and mistakes are unique to its particular circumstances, and while these may help guide policymakers in Britain, they should in no way deter them from introducing a popular policy which would allow terminally ill patients to end their suffering.

Canada introduced medical assistance in dying (MAID) in 2016 after the supreme court overruled the then-existing ban on the practice based on Canadians' constitutional right to life, liberty and security of person.

The 2016 version of the policy was more restrictive than those which would later emerge. Assisted dying was available only to those with serious and incurable illnesses causing them to suffer and have a reasonably foreseeable natural death, limiting eligibility to those with a terminal illness. These restrictions were challenged in the courts by those who wanted the policy expanded to allow those with painful illnesses that were not terminal. In 2019 that part of the law which required a foreseeable natural death was ruled unconstitutional by a lower court. In response the government drafted a new law providing an option for those who are physically suffering but without a foreseeable natural death, such as those living with cerebral palsy and post-polio syndrome. That bill specifically excluded mental illness from the eligibility criteria until it could be studied further, with a decision delayed until 2027. Canadian Conservative leader Pierre Poilievre, who is set to be leader by then if polls are to be believed, has said he would refuse the expansion to mental health.⁵

Canada is not the only example of Medical Assistance in Dying

There are essentially three choices facing policymakers when deciding assisted dying eligibility.

- Allow assisted dying only in cases of terminal illnesses
- Allow assisted dying in cases of terminal illnesses and when the patient is experiencing physical suffering considered to be “unbearable” or “intolerable.” Defining intolerability has proven contentious, and it is often left up to the patient and their physician
- Allow assisted dying in cases of terminal illnesses, physical suffering and mental suffering

Table 1: Types of assisted dying policy, and where they are allowed

Eligibility	Countries	Explanation
Allow assisted dying for terminal illnesses	Australia ⁱ , New Zealand, United States ⁱⁱ ,	<ul style="list-style-type: none"> • Applies to diseases likely to cause the death of an individual • Examples include late stage cancers and cardiovascular conditions • Generally, timelines are required. For instance in the Netherlands, physicians must expect illnesses to cause death within six months
Allow assisted dying for terminal illnesses and physical suffering	Canada, Colombia, Spain	<ul style="list-style-type: none"> • Applies to terminal illnesses and diseases causing physical suffering • Examples include multiple sclerosis and cerebral palsy • Often physicians must show that the illness is irremediable. In Belgium, all alternative treatments must have been attempted
Allow assisted dying for terminal illnesses, and physical and mental suffering	Belgium, Luxembourg, Netherlands, Switzerland,	<ul style="list-style-type: none"> • Applies to terminal illnesses and diseases causing suffering • Examples include diseases causing pain, both mental and physical. • Psychiatric conditions like depression may be eligible

ⁱ In Australia assisted dying is legal in every state and territory apart from the Northern Territory.

ⁱⁱ Assisted dying is available only in the following US jurisdictions: Oregon, Washington State, Vermont, California, Colorado, DC, Hawaii, New Jersey, Maine and New Mexico, and it has been decriminalised in Montana

The first dividing line between international jurisdictions is whether they allow assisted dying for those with non-terminal illnesses. Oregon and other US states, as well as Australia and New Zealand only permit assisted dying for a person with a terminal illness. Canada, alongside Belgium, the Netherlands, Luxembourg, Spain, Switzerland, Austria, and Colombia, allow for the procedure in certain non-terminal cases, and are based on legal protections for medical practitioners who see a conflict between their duty to relieve distress and the needs of their suffering patients.

The second dividing line is whether mental suffering should be seen to make someone eligible for assisted dying in a similar form as physical suffering. Currently, of those countries which permit assisted dying for non-terminal illnesses, all but Austria explicitly allow mental illness as a potential cause. However, in practice, access varies depending on conditions. While dementia may be included as a mental illness in which assisted dying can be administered, psychiatric conditions like depression are only eligible in Belgium, the Netherlands, Luxembourg, and Switzerland.

The final category includes those where legality is not clear. Canada's path to assisted dying is similar to many countries, having been driven more by legal rulings in the courts than by the legislation of governments. Indeed some scholars have blamed Canadian advocates' reliance on "rights rhetoric" for distorting the discussion and overwhelming more clinical practical and ethical concerns. Being so guided by judicial rulings has further made the policy appear unpredictable, and leaves the public uncertain where expansion will go next. In Japan, Italy and Germany, court rulings have left assisted dying in legal grey areas after decriminalising the practice for doctors but failing to follow this up with clear policy.

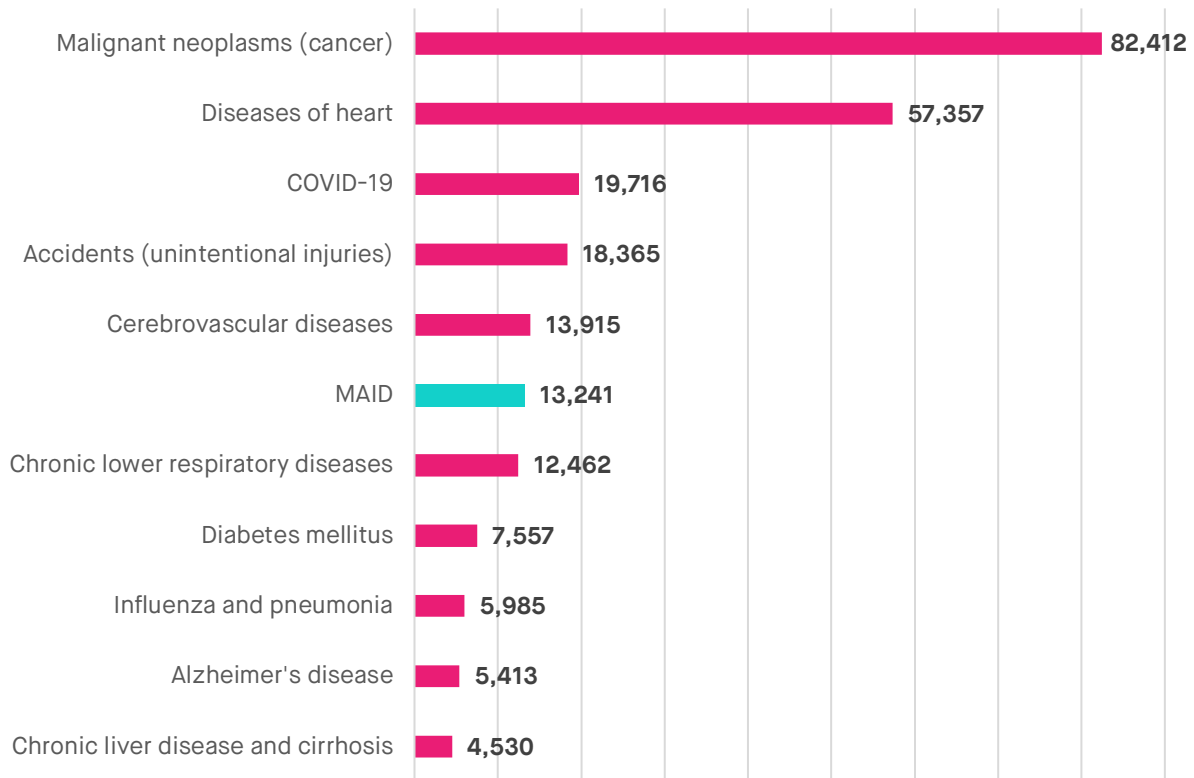
Absent a codified constitution, British policymakers considering assisted dying are unlikely to face the brute force of a legal ruling.ⁱⁱⁱ⁶ But foreign experience with opaque laws shows why making clear decisions about eligibility will be essential to protect against misapplications of the policy, create a safe and secure application process, and to reassure the public.

Who is receiving assisted dying in Canada?

In 2022 there were 13,241 MAID administrations reported in Canada, accounting for 4.1% of all deaths.⁷ This would make it the sixth highest cause of death in the country. Since its introduction in 2016, 44,958 medically assisted deaths have been recorded.

ⁱⁱⁱ A judicial decision had similar implications in Scotland following *Ross v Lord Advocate*, which clarified that the Scottish law was in line with the ECHR

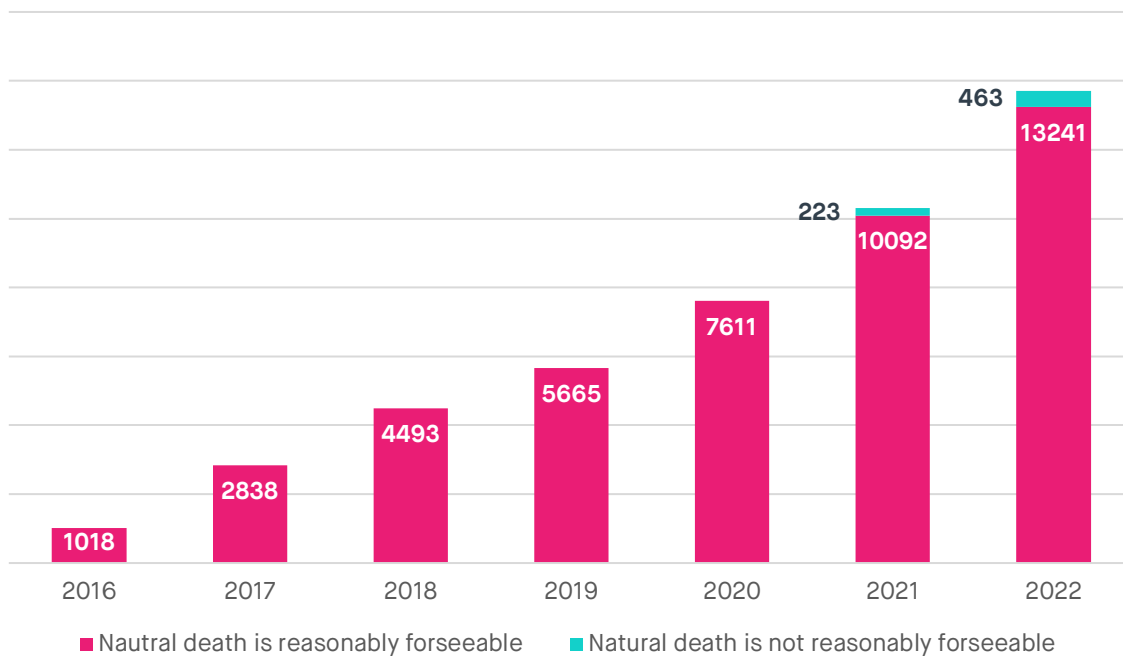
Figure 1: Leading causes of death in Canada (2022)



Source: Statistics Canada⁸ and Health Canada⁹

Note: Double counting is used in the above chart as Canadian statistics record MAID deaths based on their eligibility criteria. For instance a person who receives MAID due to terminal diseases of heart will be recorded as dying from diseases of heart

This has been on an upward trend since assisted dying was introduced in 2016. The expansion of eligibility for those without a terminal illness has also increased cases. There are varying views on this issue. Some are concerned that the increase in assisted deaths will continue their upward trajectory, while others claim the increase was to be expected as the policy becomes more socialised, and that the increase should level out over time. Canada’s assisted dying rate of 4.1% is lower than the Netherlands, which has the highest rate at 4.8% but it surpasses other countries including Belgium (2.3%) and Switzerland (1.5%).¹⁰

Figure 2: Canada's recipients of assisted dying over time

Source: Health Canada¹¹

A vast majority of Canada's MAID cases (96.5%) are administered to those where death is reasonably foreseeable. These are known as "track one" cases. This requires two independent medical practitioners to confirm the person:

- have a serious and incurable illness, disease or disability where a **natural death is reasonably foreseeable**
- be in an advanced state of **irreversible decline** in capability
- have enduring and **intolerable** physical or psychological suffering that cannot be alleviated under conditions the person considers acceptable

However, many concerns have been raised over the vague terminology used in the law. For instance, how a physician defines a "reasonably foreseeable" and "natural" death is extremely variable, allowing for extreme cases. It has been found to be too vague to be applicable by some courts, who approved the application of a woman with erosive osteoporosis despite this not being a terminal condition.¹² The same is true of "irreversible decline" which theoretically excludes many conditions in which the patient is stable, such as those who suffered a stroke in the past, but in practice the wording is being applied more flexibly.¹³ Defining "intolerable pain" has also proven contentious.¹⁴

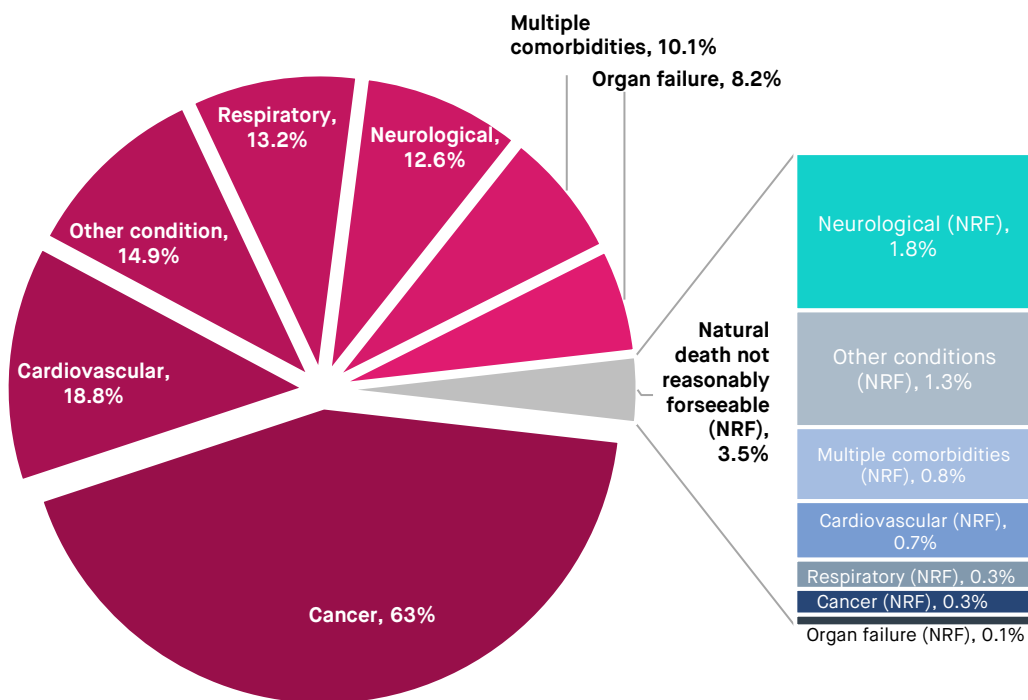
Since eligibility was expanded in 2021, assisted dying has been provided 686 times to those whose natural death was not reasonably foreseeable, and in 2022 represented 3.5% of cases. These are known as track 2 cases and a majority involve neurological

conditions. Those suffering exclusively from mental illness have been excluded until 17 March 2027. Patients must be informed of supports and services available to them and normally they must wait 90 days for eligibility assessments.

In addition to the criteria applied in terminal cases, those whose death is not reasonably foreseeable require one of the assigned medical practitioners to have expertise in the condition causing the person’s suffering, or they must consult an expert. That said, “expertise” is poorly defined, and does not require any additional education or official degrees.¹⁵ Further, approvals under this process are by their nature more discretionary, reliant on a physician’s consideration of vague terminology. The Canadian Association of MAiD Assessors and Providers (CAMAP), which provides training for physicians involved in MAiD, has explicitly instructed its members that their non-terminal cases may “become” terminal if the individuals reject treatments, thereby avoiding certain safeguards.

Among the 3.5% of cases that are not terminal, neurological conditions were the leading underlying condition, however, nearly two thirds of non-terminal cases have unclear causes, as Canadian statistics list 2.1% of all cases were listed either as “multiple comorbidities” or “other conditions,” without expanding on the nature of these diseases.

Figure 3: Underlying medical conditions of those receiving assisted dying in 2022, including those whose natural death was not reasonably foreseeable (NRF)



Source: Health Canada¹⁶

Note: The total exceeds 100% because providers were able to select more than one medical condition when reporting

Such oversight is important because one of the most common concerns cited around Canada relate to its 2021 expansion to include non-terminal illnesses. This removed a key safeguard that had prevented people with years or decades left of life from accessing MAID. Since then Canada has allowed people with serious disabilities to access assisted dying in the absence of other medical issues, and failed to adequately replace it with up-to-date safeguards.

UK policymakers can learn from Canada’s mistakes and restrict evaluation of requests to doctors

It is vital for policymakers to design strict procedures and restrictions when enacting assisted dying legislation. This will require deciding how those who desire assisted dying can make their request, who should investigate and adjudicate that request, how these investigators should interact with the applicant, what support is available to each party, and how much oversight should be involved.

Each of these is critical to creating a safe process that the public can trust. Take the case of Alan Nichols, a sixty-one-year-old from British Columbia, who was hospitalised in 2019 over fears he might be suicidal. Within a month he had submitted a request for medically assisted dying from within the hospital. Nichols cited hearing loss, which he had had since he was twelve and for which he had been given a cochlear implant that he had taken out. Other issues which may have arisen included seizures, however his family noted these had not occurred in the ten years leading to his death nor are they considered terminal.¹⁷ Despite these circumstances, Nichols’ request was approved and he received assisted dying. Afterwards, Nichols’ family reported the case to authorities, but was told hospital staff were not liable as Nichols had met the criteria for assisted dying.

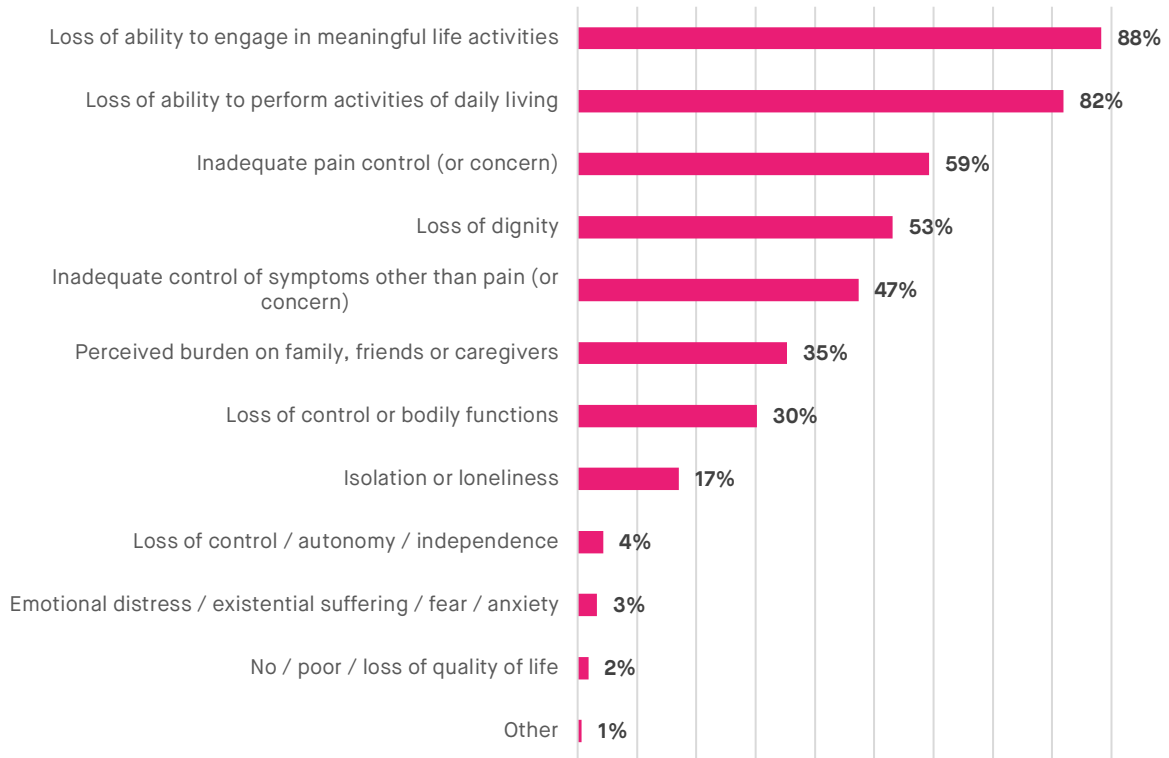
The case sparked controversy in Canada and abroad over how the country processes applications. It raises questions about who can evaluate applications, the process they must follow to do so, and what factors must be taken into account.

Canada was the first country with medically assisted dying to allow nurse practitioners to assess and approve MAID applications alongside licensed physicians. This is concerning for two reasons. The first is nurses’ expertise. While nurses may be closer to the patient or have spent more time with them, they may also lack relevant understanding of the diseases from which the patient is suffering. Education materials provided for nurses and nurse practitioners in Canada are minimal, and in some provinces only included three or four pages.¹⁸ This is particularly concerning in the context of Canada’s vague criteria and definitions which leave an unusual degree of discretion to the reporting physician.

Further, international studies from abroad have shown the important and subtle role nurses perform in discerning the intent of the initial requests, as they are viewed by the patient as slightly outside the medical system.¹⁹ Allowing nurses to adjudicate on requests risks blurring their roles and undermining these functions. Thirdly, given that nurses are generally expected to follow doctors' orders, some reported feeling uncomfortable about denying a doctor's request for assistance with a MAID application.²⁰ This may have influenced the approval of Nichols, as at least one clinician who recommended MAID for his case was a nurse practitioner.²¹ While fellow-doctors may be more willing to challenge their peers' conclusion, asking nurses to do so puts them in a difficult professional position.

Case evaluation is not always simple, and many applications will require external support

As part of each case in Canada, those receiving MAID are asked about the nature of their suffering. Certain reasons, such as coercion or suicidal episodes, are meant to be flagged and could lead to a rejection. Yet many cases appear to have snuck through. Over a third (35%) of people who received MAID listed as part of their reasoning the perceived burden on family, friends or caregivers, while 17% cited isolation or loneliness. In the case of Alan Nichols, his brother later explained "He would go through stages where life was good and then he'd hit a stage for a while, for a month or two, where he didn't feel like living."²² In another case, a quadriplegic man who contracted an infection which would take months to heal opted instead to receive MAID, citing the burden on others. Although his condition was not terminal or irremediable, he was nonetheless approved.²³

Figure 4: Nature of suffering of those who received MAID in Canada (2022)^{iv}

Source: Health Canada²⁴

Not all of these cases are concerning. When terminally ill, it is natural that one might feel they are a burden or experience feelings of isolation. It is when these social factors become an individual's primary motivation for assisted dying that there is reason to be concerned. But these cases are difficult to define and flag.

In theory, Canadian practitioners are expected to reject applications which they feel are motivated by suicidal intent or manic episodes, but these are difficult to recognise, particularly when applicants suffer from other physical conditions that might make them eligible. Further, implicit motivating factors are even more difficult to detect, such as receiving assisted dying primarily because one feels they are a burden. Concerns about disability and inequality also apply in these cases.

As such, it is vital that vulnerable people be protected from assisted dying by ensuring providers have adequate training and clear procedural guidelines to help them recognise red flags. Expanding support available to medical practitioners can provide useful expertise, especially when these are coupled with strict regulations on when physicians need to seek these out. Education materials can form a foundation to help physicians understand the assisted dying process and their role in protecting

^{iv} Note that the total exceeds 100% because providers were able to select more than one medical condition when reporting

safeguards. Further, in the Netherlands, independent psychiatrists are required to ensure patients are competent and not suffering from depressive, manic, or psychotic symptoms that could be influencing their wish.²⁵ In these cases, physicians may hold moral case deliberation sessions with colleagues and consult with other practitioners at length. Such support may have led physicians to reject Nichols' application.

Policymakers should focus on allowing assisted dying in cases of terminal illnesses, due to the risks required to include physical or mental suffering

Policymakers hoping to legalise assisted dying are likely to face questions regarding eligibility. Will the UK follow the US, Australia and New Zealand and legalise policy exclusively for terminal cases, or will they follow European countries to cover physical suffering and mental illness?

When it comes to physical suffering, the process for seeking assisted dying is generally straightforward. Internationally, applicants will usually require two physicians to sign a statement saying that the patient is suffering and that there is no adequate treatment or reasonable expectation of relief.

One key area of concern regarding these cases is on issues of inequality in the disabled community. Since 2021, Canada's law has effectively allowed anyone with disabilities to access MAID, so long as their condition is incurable. This is concerning because disability and long-term illnesses can leave patients in poverty with very few options. The case of a woman in a wheelchair with chemical sensitivities caused concern in Canada after she gained approval for MAID in response to not being able to afford an accessible apartment.²⁶ "I've applied for MAID essentially...because of abject poverty" she told journalists. In a separate incident, a veteran and former Paralympian alleged they were told by a veterans' caseworker that they could not provide her with a wheelchair ramp but that assisted dying was available as an alternative.²⁷

Examples like these provoked the UN Special Rapporteur on the rights of persons with disabilities to issue a statement warning the policy would violate human rights standards, and recently, a coalition of disability groups launched a constitutional challenge due to their concerns.²⁸ In Ontario in 2023 63% of non-terminal assisted deaths had a disability, and 76% required disability support. These cases turn compassionate arguments about alleviating suffering into difficult discussions on discrimination, as inadequate social care, health care, and housing motivate people to choose a premature death.

And while affordability impacts physical health, mental health treatments are even less accessible to poorer individuals and often involve high private costs. This systemic inequality has provoked concerns from mental health organisations who fear assisted dying will be more attractive to those who cannot access treatment, including poorer groups and ethnic minorities where psychiatric conditions are more

prevalent. There appears to be evidence for this, as nearly half (48%) of those in Ontario who accessed MAID in 2023 without a terminal illness belonged to the most marginalised quintile in terms of residential instability. The Canadian Human Rights Commission has warned that safeguards must be in place to protect vulnerable populations.²⁹ One witness told a government joint committee “This stretching of MAID is not a benefit advancing equality. It's quite the contrary. It aggravates discrimination, marginalization and inequality.”³⁰

Offering assisted dying in these conditions also limits the ability of patients to acclimatise to new conditions. In the case of new life-altering conditions, such as paralysis or blindness, acclimatisation can take years, requiring long periods of adjustment. But most eventually adjust, especially if they are provided adequate resources and care. Offering assisted dying to these individuals, particularly if the offer comes while one is still processing their diagnosis, could prevent them the opportunity to adjust to their new difficulties.³¹

Concerns were also cited regarding the expansion related to physician education and capacity. Questions were asked about how medical practitioners could make decisions on mental health applications without the appropriate training, after a 2024 Senate report found the curriculum available to train them lacks key information on identifying suicidality and vulnerability.³² Even with the appropriate training, the report also found it difficult (if not impossible) to make a long-term prognosis of whether a mental health disorder is irremediable, and cited statistics showing a majority of psychiatric professionals in the country opposed expansion.³³

Finally, there is always the risk that, even if applications are rejected, applicants can search for a different physician with more flexible views on eligibility. This practice of “doctor shopping” has been noticed by academics and constitutes a critical failure in the system. In Ontario, the largest Canadian province, 40% of those who eventually received MAID for non-terminal conditions had been rejected by at least one doctor. That these individuals are able to sidestep rejections until they find a more lenient doctor implies there are very few obstacles capable of preventing assisted dying for dedicated individuals suffering from non-terminal conditions.

Safeguards are available for policymakers who wish to legalise assisted dying while accepting concerns about Canada

The UK should decriminalise assisted dying for terminal illnesses and, alongside the British Medical Association, design an application process for patients to follow. Following common practice in other countries, this would likely require the signature of two physicians who can testify that an illness is likely to be terminal within six months and that there are no reasonable alternative treatments. Additional safeguards can be added that protect patients and doctors, including those related to procedure, oversight, and palliative care.

Safeguard area one: clear procedure

Extremely detailed guidelines are in force in the Netherlands, with legal repercussions for physicians who do not act in accordance with them. This requires in-depth discussions between the physicians and the patient, guided primarily by legal criteria but influenced by each doctor's interpretations and personal considerations.³⁴ As a Dutch doctor described to the Canadian Medical Association Journal, "This is the relational aspect. I often feel there are medical options. I argue with my patients until we have agreement. If I'm going to do it, I have to be sure."³⁵ Another physician explained this relational aspect in how he attempts to have in-depth conversations before agreeing to an application, even if the patient pushes back:

*"For me talking about and reflecting on life and death is a necessary condition to perform [assisted dying]. But you can't reasonably expect that from certain people, that they are able to do that. Perhaps I should recognise that earlier and say to those people: sorry I won't be able to perform EAS on you because I can't have a deep enough conversation with you about it and then it doesn't feel right. And I learned not to do these things when it doesn't feel 100% right, otherwise I can't sleep at night. But the thing is, I do treat people unequally this way."*³⁶

Dutch doctors are therefore obliged to do everything in their power to ascertain the true nature of a person's suffering, and are allowed to do so in their own way. For instance, Belgian doctors are required to have "multiple conversations" spread over "a reasonable amount of time" to ensure all criteria are met.³⁷ Contrast this method with a Canadian physician who administers MAID, who told *The Guardian* "I ask a lot of questions, but I tend to trust my patients. And so in their answers, until I'm proven otherwise, I assume they're telling me the truth."³⁸

Canada's less confrontational method may be linked to the rights-rhetoric that has dominated national discussions and which frames the policy as an inherent freedom. There is no legal requirement in Canada on the amount of conversations which are required nor their quality. This could explain why assisted dying is so rarely refused in Canada. In 2022, just 3.5% of applications were deemed ineligible, while in the Netherlands this rate is 30%.³⁹ In combination with the British Medical Association, policymakers should work to establish legal guidelines that mandate doctors ask key questions and require them to reject applications in which they are not confident. Such methods are more invasive, but the cost to designing a less confrontational approach is that vulnerable individuals are not protected.

Forbidding physicians from being the first to discuss assisted dying is another safeguard worth pursuing. Belgian doctors are advised to avoid bringing up assisted dying as it could be interpreted as medical advice, while in New Zealand and the Australian state of Victoria doctors are explicitly forbidden from raising the topic first. Victoria's agency responsible for the review and monitoring of assisted dying found

that this prohibition may explain why rates of assisted deaths are lower than in comparable states which allow it, like Western Australia and Queensland.⁴⁰

In contrast to Victoria, Canadian physicians face fewer restrictions on their interactions with applicants, and are instead told they have a “have a professional obligation to initiate a discussion about MAID if a patient might be eligible for MAID” by the Canadian Association of MAID Assessors and Providers, which provides guidance to professionals on the subject.⁴¹ This is particularly dangerous from those on low incomes or the mentally ill, who might be coerced through power dynamics common in doctor-patient relationships, or who may be more likely to misinterpret the discussion as medical advice.

It is possible that fears of prosecution could make doctors hesitant to discuss assisted dying even when it comes to eligible cases. However, this cannot be an argument against clear procedure and safeguards, and such concerns can be mitigated by clarifying the requirement to the medical community. Any law or regulation on the subject must provide clarity to doctors on how to respond when an individual brings up assisted dying and the appropriate steps which they need to initiate, to ensure they understand the relevant laws and required procedure instead of feeling confused by them.

Providing assisted suicide rather than euthanasia can help ensure those involved in the process remain comfortable and safe, including the patient themselves. Euthanasia applies to cases where a physician injects or directly administers a lethal drug, and in Canada, this is used in the vast majority of assisted dying cases. With this method, patients must schedule a specific time with physicians either in a hospital or at home, the physician injects them with the drug, and leaves following their death.

In contrast, many American states including Oregon and California see higher uptake of physician-assisted suicide, in which a physician prescribes oral medication for the procedure but it is up to the patient, when, where and how to take it, allowing for longer reflection time and introspection. This is known as the oral protocol, and while most Canadian provinces allow for this method, it is rarely used, and only seven of the 10,064 assisted deaths in 2021 were self-administered in this way.^{42v}

Doctors and scholars have warned that the tendency to use euthanasia in Canada may increase pressure on applicants to follow through with the procedure once it has been set in motion, particularly if they feel their doctor approves of the choice.⁴³ It is possible that having ownership and control of the substance gives individuals more chance to reflect on their decision. Behavioural impulses may also play a role, if individuals feel awkward or hesitant about cancelling an appointment for which their

^v In certain cases, including in Scotland’s current bill, this is known as “self-administration”, where individuals who cannot take the substance orally are able to do so in some other way, for instance pushing down on a plunger after a nurse fits a line for them.

family and physician have already prepared. In Oregon, one of the few states with data on the issue, there were 431 prescriptions made in 2022 but only 278 deaths, implying 35% of applicants reconsidered. Californian rates are similar, with 30% to 35% who were prescribed the medication never using them.⁴⁴ In Canada, just 2% of applicants withdrew their requests, while 14% died of natural causes.⁴⁵ It is possible the higher withdrawal rates in American states can be partially explained by individuals holding onto assisted dying medication as a precaution, in case their illness rapidly deteriorates, and who never plan on taking it if it is avoidable.

However, the extreme difference in withdrawal rates between the jurisdictions is cause for concern. The oral protocol may act as an additional safeguard, ensuring that the final choice these individuals make is autonomous, limiting the role of the physician in their decision. Part of the benefits of this process is the privacy patients are provided. Without the presence of a doctor or an appointment, those prescribed assisted dying bills can choose to die at their convenience and without the presence of strangers, which some opposition to legalisation have voiced concern over.⁴⁶

In order to ensure patients feel comfortable reconsidering their options even at the last minute, policymakers should ensure that the oral protocol is the default method applied in these cases, only allowing for euthanasia in cases where an individual is incapable of self-administering the dose. Physicians may be available on a patient's request, but not as a requirement. Victoria, Australia's assisted dying act may be instructive in this regard.⁴⁷

It should be noted that bills currently advancing through the House of Lords and the Scottish Parliament ensure assisted dying will be done through self-administered medication, but they also currently require a doctor to be present. This has been done to ensure the medication is returned if it is not administered so that the practitioner would not risk legal liability if the substance was to end up in the hands of someone other than the patient. While well-intentioned, this will likely do more harm than good. Such cases are exceedingly rare, and while concerning, the risks pale in comparison to the risks seen when legislation requires doctors to be present. Comparing the risks involved in each method, the path of maximum caution would allow patients who wish to die without a physician present the option to do so, when and where they wish.

Safeguard area two: active oversight

Specially trained consultants are available in Belgium and the Netherlands upon request within 48 hours to assist physicians, patients, and family members and ensure procedure is followed.⁴⁸ These consultants read the medical files, examine the patients, and ascertain whether they meet the conditions for assisted dying.⁴⁹ They are well trained, with at least five years experience as a physician, have experience in the field of euthanasia, be considered skilful in consultations, and receive roughly 24 hours of training which includes guidance on legal duties and communication. They also meet multiple times a year to discuss cases and air any problems. In Canada, consultants are only available after ten days, hampering access to help and

disincentivising their involvement.⁵⁰ Teams based on Dutch and Belgian standards should be assembled regionally across the UK to assist doctors, particularly in the early stages of assisted dying when uncertainty about eligibility will be highest.

Regional committees are further available after an assisted death to review the case, providing clear guidance for future cases and consequences for clinicians that fail to follow strict guidelines. These boards have helped investigate cases that breach legal standards or codes of ethics, and help keep the process reliable and secure.⁵¹ In Canada these are not required, and only now are some provinces beginning to establish committees to review MAID deaths and provide oversight. However, these have not been given the resources of European counterparts. For instance, Ontario's Office of the Chief Coroner announced in 2023 it would form a committee of up to twelve members to meet ten times a year for between four and five hours. The committee is expected to oversee a province which saw 3,934 MAID deaths in 2022, compared to Dutch committees which operate on a smaller scale and cover, on average, less than half that number (1744 in 2022).⁵²

This is not to say review committees in the Netherlands and Belgium are perfect, and questions have been raised regarding the effectiveness of such bodies.⁵³ One researcher we spoke to on the subject pointed to the countries' low rate of prosecution even in clearly disturbing cases. He blamed the self-reporting system physicians use, likening it one which asks drivers to notify authorities every time they speed. Any regional committee established in the UK must therefore be capable of investigating cases and randomising site visits to ensure due process is met. Guidelines should be clear enough that regional review committees and local officials feel capable prosecuting cases where the physician has failed to follow the legal criteria.

NHS England's regional teams would be ideally placed to develop regional committees to review cases, however it is possible due to population sizes that some regions would need multiple committees. Even Dutch oversight levels, which are significantly more focussed than Canadian equivalents, may have too high a caseload to ensure a safe system, and more resourcing may therefore be required. Policymakers should learn from international experience to establish a maximum number of cases committees are capable of investigating, and plan to add more committees where existing ones become overwhelmed.

Data collection is administered by regional committees and released annually to prevent disinformation. While reports are released annually by Canadian agencies, data collection across provinces are patchy, and experts have been concerned that they do not track factors related to inequality.⁵⁴ While data on race and disabilities will be reflected in the government report to be published in 2024, no data on income has been promised.⁵⁵ Safeguards allowing the involvement and analysis of external experts can decrease variation in practice and prevent misapplications of the law while alleviating anxiety about the practice among the public.

Safeguard area three: available alternatives

Reasonable alternatives must be exhausted for Belgian or Dutch applicants to receive assisted dying.⁵⁶ This means the physician must be satisfied that there are no routes available to the applicant, such as pain management care or recovery-oriented treatments, which could sufficiently alleviate their condition. This may involve requiring applicants who have not undergone viable treatments to attempt them.⁵⁷ Only once a doctor is confident that the individual has exhausted all reasonable treatments can doctors allow assisted dying.

Canada does not include this stipulation, and while the law theoretically requires illnesses to be “incurable,” “irreversible;” and which “cannot be alleviated under conditions the person considers acceptable,” in practice these requirements have been more flexible.⁵⁸ Doctors are allowed a high degree of discretion in determining how these requirements are interpreted and what factors are prioritised, allowing clinicians to provide assisted dying to those who might not have attempted certain treatment options. It also only requires patients hear the options, and there is no duty on the medical community to ensure those options are made available. As a result there is a growing body of narrative accounts which describe those receiving assisted dying due to suffering associated with limited access to medical, disability, and social support.⁵⁹ Instead, English law may require doctors to ensure applicants have attempted any reasonable treatment options before they allow assisted dying.

Palliative care focusses on patients with serious illnesses to manage pain, symptoms, and stress, and is often used for those with incurable conditions. No one should be forced to use assisted dying because it is not available or is not affordable, and yet it appears many are in this position. In Ontario in 2023, just 51% of non-terminal MAID cases had been offered health care services and palliative care in order to relieve their suffering.

According to the Marie Curie charity, 90% of British deaths could benefit from receiving some form of palliative care.⁶⁰ This means that in 2019,^{vi} 450,000 people in England needed end of life care, but according to the Office of Health Economics, just 378,427 received it, meaning one in six people could not access the care they need.⁶¹ Hospice UK was even more concerned, estimating that one in four individuals cannot access end of life care, with the most disadvantaged in society the least well-served, including those in poverty, ethnic minorities, and the disabled.⁶² This gap exacerbates the risk that individuals may feel pushed towards assisted dying, if it is an option. Canada’s experience testifies to this, with 59% of assisted dying recipients experiencing inadequate pain control and 35% concerned about the impact of their illness on friends, family, or caregivers.

^{vi} The last year for which we have data before the COVID-19 pandemic affected data related to death and care needs

To protect these individuals from dying before they wish, resources should be devoted to increasing the provision of palliative care and chronic care support at home, as Austria did when its legislators legalised assisted dying, in order to ensure no one chooses assisted dying when other options are available.⁶³ These methods can ensure assisted dying for terminal cases remains safe while reassuring the public.

Non-terminal suffering remains controversial. While there is an emerging majority on the issue of terminal illnesses, when it comes to potentially expanding assisted dying to allow cases for non-terminal suffering and mental illness, policymakers should go slow. These are matters of extreme nuance. The cases of people choosing to die rather than live in poverty or with disabilities are alarming, as are those who have been able to access assisted dying even for conditions which might have alleviated given time. These have also become so prevalent in Canada that they have overwhelmed the public conversation, heightened anxiety, and turned what should be a compassionate policy into a topic of polarisation and concern.

This will require terminal illnesses to be clearly defined. Even before Canada extended eligibility to include non-terminal cases, MAID applications were being accepted in controversial cases.⁶⁴ This has been blamed on the vague wording applied in Canadian law, which stipulates that the applicant's "natural death be reasonably foreseeable."⁶⁵ In contrast, American and Australian jurisdictions require death be foreseeable within a certain timeline, for instance, six months.⁶⁶ Without a timeline, Canada's definition leaves room for a wide range of interpretations. Treatable early stage cancers may be considered eligible, or for conditions under which the applicant has decades left to live. In addition, because Canada did not require treatment alternatives to be exhausted, applications could be accepted to be terminal despite treatment options being applicable. A Canadian legal professor explained how a person with a simple infection could hypothetically access MAID by refusing antibiotics. These cases are not just hypothetical, as shown by CAMAP instructing its members that non-terminal cases can "become" terminal if they refuse treatment. As such, in addition to establishing a clear timeline, policymakers should require treatment alternatives be exhausted, as is already the case in Dutch and Belgian law.⁶⁷

It is important to remember that these safeguards will not exist in isolation, but will be in constant relationship with each other and with the wider social and medical system. They will require well-functioning services capable of providing adequate care regarding medicinal, housing, income, and social needs. By barring those without terminal conditions from accessing assisted dying, we are not dismissing the authenticity or severity of their suffering, but recognising we must provide them with other options.

Conclusion

No part of Canada's experience provides a reason to rule out assisted dying for terminal illnesses. Neither does it provide comprehensive arguments against the eligibility of those suffering from non-terminal but irreversible medical conditions. Rather, Canada provides lessons in the appropriate definitions of eligibility and the need for safeguards as the UK considers introducing the policy.

Throughout the COVID-19 pandemic, public conversations were focussed on death. As news programs aired images of families forced to say goodbye to their loved ones over Zoom, many of us considered for the first time how we want to end our life. The desire to choose the manner of our death, when it takes place, and who we want present, became more urgent.

That desire is reasonable, and Canada's experience does not outweigh the just demands of 75% of the population who support assisted dying legislation. Other countries show the appropriate path forward for assisted dying in the UK, and with the appropriate caution, we can get there.

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